New Jersey Department of Health and Senior Services
Long Term Care Licensing Program
PO Box 367
Trenton, NJ 08625-0367

APPLICATION FOR A HEALTH CARE FACILITY LICENSE

Type of Application:	**Date of Application:**	**Date of Check/Money Order:**
☐ New – CN#: _____		
☐ New – No CN Required, ID#: _____	**Check/Money Order No.:**	**Amount of Check/MO:**
☐ Transfer of Ownership #: _____		**$**
☐ Other: _____		

Official Name of Facility (Provider Name):			**EIN Number:**
Site Address:			
City:	State:	Zip:	County:
Telephone Number:	Fax Number:		Email Address:
Name of Administrator:			License Number (LNHA/CALA if applicable):
Emergency Contact:			
Emergency Telephone:	Emergency Fax Number:		Emergency Email Address:
Mailing Address (if different from above):			
City:	State:	Zip:	County:

Owner/Corporate Name *(LICENSED OPERATOR)*:			**EIN Number:**
Doing Business As (if applicable):			
Address:			
City:	State:	Zip:	County:
Telephone Number:	Fax Number:		Email Address:

Management Company (if applicable):			
Address:			
City:	State:	Zip:	County:
Telephone Number:	Fax Number:		Email Address:
Contact:	Title:		

APPLICATION FOR A HEALTH CARE FACILITY LICENSE, Continued

Official Name of Facility (Provider Name):	**EIN Number:**

Primary Type of Facility *(check one)*

☐ Adult Day Health Services	☐ Hospital Based Subacute	☐ Long-Term Care T18 only
☐ Alternate Family Care	☐ Pediatric Day Health Services	☐ Long-Term Care T19 only
☐ Assisted Living Program	☐ Residential Health Care Facility	☐ Long-Term Care T18/19
☐ Assisted Living Residence	☐ Other:_____	☐ Long-Term Care Private
☐ Comprehensive Personal Care Home		

Enter the Quantity of all Beds/Slots at this Location

Adult Day Health Service Slots.....	_____	Long-Term Care Beds	_____
Assisted Living Beds.....	_____	Pediatric Day Health Slots.....	_____
Comprehensive Personal Care Beds.....	_____	Residential Health Care Beds	_____
Hospital Based Subacute.....	_____	Other/Type:_____..	_____

Type of Ownership *(check one)*

For-Profit	Non-Profit	Facility is Hospital Based	Government Owned	
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
☐ *Corporation	☐ Proprietorship	☐ Limited Liability Corp.	☐ Federal	☐ City
☐ Partnership	☐ Limited Partnership	☐ Religious Affiliation	☐ State	☐ City/County
☐ Other(specify): _____			☐ County	☐ Hospital District

**If the corporate entity is a wholly-owned subsidiary, identify the parent corporation below:*

Name: _____

Address: _____

City, State, Zip Code: _____

Building Ownership *(check one)*

☐ Wholly owned by licensed operator identified on page one

☐ Leased (Identify owner of physical assets and submit a copy of the signed lease)

_____

Name and Title of Individual or Current Registered Agent Upon Whom Orders May Be Served *(Must be NJ Resident)*

Name: _____

Address: _____

City, State, Zip Code: _____

Official Name of Facility (Provider Name):	**EIN Number:**

OWNER, OFFICERS, PARTNERS, STOCKHOLDERS, OR CORPORATE OFFICERS

- *IDENTIFY 100% OF THE OWNERSHIP BELOW.* (Attach additional sheets if necessary.)
- *For a publicly-held corporation, identify all stockholders with 10% or more of the outstanding stock.*
- ***If an owner, partner or shareholder is an entity, rather than an individual, provide the individual ownership of that entity as well.***
- *For Non-Profit entities, list Board Members.*

Name: ______
Title: ______
Address: ______
City: ______
State: ______ Zip Code: ______
SSN/Tax ID: ______
% Ownership: ______
☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

Name: ______
Title: ______
Address: ______
City: ______
State: ______ Zip Code: ______
SSN/Tax ID: ______
% Ownership: ______
☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

Name: ______
Title: ______
Address: ______
City: ______
State: ______ Zip Code: ______
SSN/Tax ID: ______
% Ownership: ______
☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

Name: ______
Title: ______
Address: ______
City: ______
State: ______ Zip Code: ______
SSN/Tax ID: ______
% Ownership: ______
☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

Name: ______
Title: ______
Address: ______
City: ______
State: ______ Zip Code: ______
SSN/Tax ID: ______
% Ownership: ______
☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

Name: ______
Title: ______
Address: ______
City: ______
State: ______ Zip Code: ______
SSN/Tax ID: ______
% Ownership: ______
☐ Proprietor ☐ Limited Partner ☐ Stockholder
☐ Partner ☐ General Partner ☐ Corporate Officer
☐ LLC-Member

APPLICATION FOR A HEALTH CARE FACILITY LICENSE, Continued

Official Name of Facility (Provider Name):	**EIN Number:**

Please indicate whether or not your facility offers the following:

	Yes	No	No. of Beds
Separate Units for Young Adults (Ages 21 through 64):	☐	☐	_____
Pediatrics:	☐	☐	_____
Ventilator:	☐	☐	_____
Behavioral Management:	☐	☐	_____
Private Long Term Care:	☐	☐	_____
Alzheimer's/Dementia:	☐	☐	_____
IV Therapy:	☐	☐	

Chronic Dialysis:	Yes	No
Performed by In-House Staff:		
-Peritoneal:	☐	☐
-Hemodialysis:	☐	☐
Performed by Outside Firm:		
-Peritoneal:	☐	☐
-Hemodialysis:	☐	☐

Assisted Living Programs and Alternate Family Care, list counties served from office site listed on page one:

_____

_____

_____

_____

Please answer the following questions. (Attach additional sheets if necessary.)

1. Have you or any person mentioned in this application ever had an interest, directly or indirectly, in any application for health care facility in New Jersey or any other state, which was denied or revoked?
   ☐ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):

   _____

2. Do any of the principals have ownership, management or operational interest in any other licensed health care facility in New Jersey, or any other state?
   ☐ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):

   _____

3. Are you related to any person who now operates or has ever operated a health care facility in New Jersey or elsewhere?
   ☐ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):

   _____

4. Have any principals, owners, operators or managers of the facility ever been found guilty of a criminal or administrative charge of resident/patient fraud, abuse and/or neglect? Have any of these ever been indicted for the same charge?
   ☐ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):

   _____

5. Have any principals, owners, operators or managers of the facility ever been indicted for or convicted of a felony crime?
   ☐ Yes ☐ No If Yes, indicate whom and give details (attach additional sheets if necessary):

   _____

CERTIFICATION

The applicant certifies:

1. that all information contained in this application and attachments is true and correct, to the best of his/her knowledge and belief, and that willful misrepresentation of these facts may make the applicant subject to civil penalties;
2. that the application been duly authorized by the governing body of the applicant; and
3) that the facility has been and will be operated in accordance with applicable licensing requirements.

Name of Authorized Individual Completing Application (Print or Type)	Title

Signature	Date